Human Values in the Care of the Surgical Patient

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Viewing ethics in surgical practice as applying critical thinking to issues of human values leads to 4 levels of consideration: the individual patient, the surgeon, surgical research and education, and surgical organizations. This perspective starts with quantitative and qualitative feedback from patients, studies of the process of surgical decision making, and understanding how surgeons matter in preoperative counseling and postoperative recovery. Surgeons should become as active in research on the psychosocial aspects of surgical care as they are in research on the biological. Based on this information, surgical training should become explicit in preparing surgeons for patient-centered management of surgical care. Finally, surgical organizations can help by recognizing research in the human values domain, setting standards that recognize feedback from patients, and addressing more formally the needs of underserved populations. This approach fails to give the basis for clear answers but gives priority to more understanding of the moral dilemmas faced by patients and their surgeons.

Interest in applied ethics has grown enormously and the intensity of interest is appropriate because of the sweeping social changes affecting surgical practice. The growth of Western-style democracy, for example, fosters the development of educated, individual citizens for its political institutions and when these citizens become patients they are much more interested in controlling their medical decisions, especially in the Information Age. The lack of a dominant religious tradition has spurred the search for a secular and pluralistic ethic, which leads people to seek guidance outside a particular religious authority. And, finally, a global worldview necessitates living with, understanding, and responding to marked differences in culture and values. Thus, major social and political forces create the need for surgeons and other professionals to rethink their practices and respond by creating codes, guidelines, alliances, etc, that fit the cardinal goals or values of surgery to the new environment.

Some approaches to applying ethics to medical practice have relied heavily on input from philosophical ethical theories to derive norms for medical practice. These approaches have the advantage of avoiding messy and contentious practical details, arbitrary distinctions, and historical determinism. Philosophical ethics can also be more responsive to the broader social, political, and economic shifts. Surgeons, like other professionals, however, tend to continue to do what has worked in the past. Change comes more gradually than an external philosophical view would promote.

A different approach to applying “ethics” to surgical practice is one that views questions of human values as central. This approach is anchored in the reality of common, everyday behavior and practice and takes this behavior and experience as relevant (albeit not determinative) to questions of changing patterns of practice. This approach to applied ethics finds underpinnings in writers like Charles Taylor and Alasdair MacIntyre. In medical ethics, writers like Howard Brody, Arthur Caplan, Troyen Brennan, and Carl Schneider take an approach based on the experience of practitioners and patients, quantitative and qualitative empirical studies of medical practice, as well as the sweeping social changes mentioned above. A “human values” approach to ethics starts by critically reviewing surgical care and practice and connecting the importance or value of the surgeon’s technical skill with questions of appropriateness and acceptability or the proper standard of care. The terms appropriateness, acceptability, and standard of care are commonly used in sur-
gical practice and carry an ethical meaning because they are the terms frequently used to justify a procedure or operation or to describe whether it was “right” or “wrong.” As described below, a values perspective also leads to questions about surgical research, the need for management skills, and the politics of surgical organizations.

Applying a human values perspective to the care of the surgical patient can be divided into a series of connected questions grouped under the following 4 headings. First, what are the needs of the surgical patient? Second, what are the requisite skills or competencies of a “good” surgeon? Third, what is best curriculum and method for training new surgeons as well as continuing education for established surgeons? Finally, what is the role of surgical organizations and what political causes should they champion? A values perspective connects these headings: understanding patient values leads to understanding the qualities of a “good” surgeon, which in turn affects surgical training and the values influencing the priorities of surgical organizations. These topics and questions, at least in part, need empirical study by quantitative and qualitative social science. A values approach therefore provides an impetus and enormous opportunity for surgeons and surgical trainees to study surgical practices empirically and critically. Some of the questions generated under these 4 headings are summarized herein.

A major caveat to the values perspective for examining surgical practice is that it fails to give clear grounds for “ethical” change (and ethics by definition concerns what we should do, not what we do). As a result, a reason or set of reasons for change needs a process of deliberation to reach a consensus or more purely political means of approval. There are no universal, clear answers from this perspective. And a process for reaching consensus or agreement can be time-consuming and inefficient. In this kind of ethics, however, the quick decision is not usually the “best,” especially when it is geared to modifying or revising practices or institutions.

THE SURGICAL PATIENT

Patient feedback is now essential in any attempt to assess health care, and a human values approach to ethics in surgery begins with this foundation. Studies of surgical care have been slower in broadly incorporating this both qualitative and quantitative parameter than other branches of medicine. Studies of pancreatic resection for cancer, for instance, seldom assess the quality of life of the short- or long-term survivors and compare this with the quality of life of patients treated with more conservative surgery or other palliative measures. The modest increase in quantity of life for some patients with pancreatic cancer is assumed to outweigh any qualitative or human costs for others. While there are some dangers in attempting to quantify quality-of-life measures because of their “subjectivity” or ambivalence and ambiguity, they can be diminished by careful application and critical analysis. Studies of other more common surgical conditions, such as appendicitis, cholecystitis, and hernias, could also benefit by systematic patient feedback combined with factors like wound infections, prolonged length of stay, and rehospitalizations.

Resistance to incorporating patient feedback on surgical care has some good reasons. Patient satisfaction can vary enormously depending on the expectation and the illness circumstance. A patient with low expectations, for instance, will have a higher degree of satisfaction and a better qualitative experience than one with high expectations, and hence will give a more positive evaluation for the same quality of care. Expectations are determined in part by past experience, stories of friends, media personalities, among others. But expectations can also be set by surgeons, other members of the care team, and other medical professionals. This makes it difficult to get reliable qualitative outcomes. Nevertheless, any attempt to secure an approach to surgical care based on human values needs to begin with systematic attempts to obtain patient feedback.

One of the factors that can affect patient experience and is often more variable in surgical care is the illness circumstance. Two different patients of similar age and with similar personalities can have a markedly different experience with a condition such as appendicitis by virtue of arriving in the emergency department at a busy time, having insufficient social support after discharge, and lack of sufficient sick time at work. Such variables are not controllable by surgical care and are not easily addressed in empirical studies. Repeating qualitative outcome studies in different settings and different times, however, will help to diminish the impact of these less controllable variables.

Informed consent and medical decision making is another major area for the incorporation and study of human values in surgical care. The legal doctrine of informed consent was formulated on the basis of surgical cases like Schloendorff, Salgo, and Canterbury v Spence. In these cases, the courts created the legal obligation for physicians to inform patients about the nature, goals, risks, and alternatives for a given treatment. Surgical cases set the precedent because of their invasiveness as well as their serious and disabling risks. As a result of these legal cases, surgeons and other physicians are required to tell patients what any “reasonable” person would want to know in consenting to an operation.

Ethical considerations in medical decision making, however, go far beyond this legal framework. Placing human values at the center of surgical practice means helping patients understand the necessary information to make a decision that is best for them from their own individual perspective. This is a far greater task than the legal minimum. Patients vary enormously in their desire for information, their ability or desire to understand, and their desire to decide for themselves or desire for the recommendation of a surgeon whom they trust. Some writers, like Goldworth, describe this ethical standard for informed consent as a subjective standard.

Patients frequently want more advice and help in deciding, rather than a lot of information and discussion of unlikely risks and alternatives, especially when they face a critical illness. Indeed, in some circumstances more information may be confusing, frightening, and even impair rational patient-oriented decision making. Acute trauma and other acute surgical illnesses are likely to fall into this category or circumstance. Re-
speckling patients, which is a key feature of the human values perspective in surgical care, therefore may actually mean giving less information, providing a recommendation with confidence, and limiting discussion of expectations to those the patient wants to know.

The trouble with this subjective or individualized standard for informed consent is the potential for inadvertent paternalism or disrespect for a patient’s rights. Some patients will want to be in control of decisions even in a surgical emergency whereas others will find this profoundly distressing. To some extent patients can indicate how much control they want, but for some patients this will be variable and unpredictable.

There are several critical issues around informed consent in these circumstances: Can we learn how to tell which patients want more and which less control in decision making? Can we learn how to structure information delivery that gives patients the degree and kind of information they want? What is the influence of prior preferences and family on how patients approach decisions in acute surgical emergencies?

In the background of decision making in acute surgical situations is the issue of trust and surgeon-patient relationship. Advocates of the subjective standard notice how often patients want to rely on a trusted physician or surgeon rather than make a decision independently. This fits with traditional notions of medical ethics that rest on the patient-physician relationship. In modern health care and especially with surgical care in an acute emergency, there is usually no long-standing relationship. Specialization, a mobile society, and patients shifting from one health care system to another are some of the reasons that make the long-term, trusting relationships of old no longer possible. But are there ways to gain trust (and deserve it) in our current multispeciality and stranger-based system? What is the influence of institutional factors that generate trust? For instance, how much does it matter whether the patient trusts the hospital or system of care for making decisions or trust in a surgical emergency?

In elective circumstances, informed consent is best modeled on the idea of shared decision making. In these situations, deciding on an operation is very similar to deciding on whether to take an antihypertensive drug or undergo a computed tomographic scan. According to this model, the surgeon provides the factual details, risks, and benefits and then may offer an opinion or recommendation based on standard practice and what the surgeon believes is best. The patient supplies factual details about his or her life, desires, and goals and a decision is reached based on what alternative will best suit the patient’s values, from the patient’s perspective. In shared decision making, it is appropriate for the surgeon to recommend a procedure he thinks is best and give his reasons for that choice. But, ultimately, the patient’s values need to be predominate.

Empirical studies of patient decision making point out how often patients pay attention to advice from family members, close friends, or others they have known or heard about with similar conditions or decisions. Actual decision making may be influenced by many small factors, including insurance coverage, job situations, and other major life decisions, eg, purchase of a house or sending a child to college. Many times these factors are relevant, but in some circumstances they gain too much influence and patients later regret the decision they made. The fact of this complexity, however, indicates that the process of decision making is important and that the surgeon’s role and skills should be described more completely. Nurses, physician assistants, counselors, and others may be more help than the surgeon. Yet in some instances, direct input from the surgeon may be crucial.

The human values perspective on surgical care thus points to 2 major topics for further investigation and training: patient feedback and informed consent or surgical decision making. Indeed, we need patient input to understand the process of decision making in surgery. But in addition to purely descriptive studies of surgical care and decision making, it is necessary to include quality improvement aspects. This means trying interventions to improve care and decision making on the basis of the feedback and then assessing whether there has been a change.

THE SURGEON

Contemporary studies of surgical practice have been both laudatory and critical. Bosk found that surgeons had exacting standards and expectations for trainees but the standards were often arbitrary and idiosyncratic. Things regarded as mistakes by one senior surgeon seemed almost trivial from an outside view (like changing dressings or notifying a superior) and were not important for another surgeon. Yet if a surgical resident disregarded these arbitrary, individual practices, then the trainee’s suitability for a career in surgery was seriously questioned and he or she would be reprimanded. Bosk also portrayed surgeons as having distinctly impoverished and noncollaborative interactions. Professional standards were more likely to protect individual surgeons and give a great leeway to individual surgical judgment.

Joan Cassell, an anthropologist who studied American surgeons, described different types of surgeons—some with extraordinary manual skills and great confidence but who would put patients at great risk. Other surgeons were more thoughtful and reflective. She found considerable variability in personality as well as risk-taking and practice style. Based on these 2 studies of Bosk and Cassell, it seems that a range of styles is appropriate both for the daily practice of surgery as well as in influence within surgery as a medical discipline.

While a range of professional skills is necessary for surgery, there needs to be a boundary beyond which the judgment or ability of an individual surgeon would be called into question. Drawing the line requires experienced surgeons but, from a human values perspective, it should include input from patients and others as well. Patients would be able to judge communication skills, trustworthiness, and reliability. Getting feedback from patients could also be very helpful in establishing the kinds of skills that surgeons need to acquire to improve patient care.

Surgery has moved from relying heavily on the performance of individual surgeons to relying on a team of providers. Quality improvement therefore requires looking at many aspects of operating room and clinic function: the skills surgeons need to acquire therefore should be managerial and leadership in nature as well as the
manual skills needed to carry out specific procedures. Feedback here comes from the affected personnel—technicians, nurses, and assistants. Defining what makes for better performance will help design programs that can hone these skills.

Patients generally want 2 things from physicians: competence and compassion. It goes without saying that clinical skills are necessary to be a good surgeon. Compassion, however, is often regarded as something innate and unteachable. Surgeons are born with sympathy or compassion; trying to teach them to be compassionate is impossible. In a sense it is true that people have different innate capacities for feeling and expressing sympathy. On the other hand, surgeons can learn skills and strategies for expressing their compassion or at least learn how to avoid mistakes in patient relationships. It is also assumed that competence interferes with compassion or else that compassion can impair competence. But is this clash true? Why can’t surgeons be expected to be both competent and compassionate?

If we hold compassion to be one of the characteristics of a “good” surgeon then there needs to be a definition of what compassion means as well as a way to evaluate and teach it. Compassion of this kind could be seen as synonymous with being civil, kind, able to express a caring attitude. There does not have to be deep-seated bonding with patients. The learnable skills of compassion would include expressing sadness in giving bad news, updating family members on a critically ill patient’s condition, responding promptly to pain and suffering, and knowing how to take an interest in patients as people. There would be a set of skills that become part of the surgeon’s performance.

The movie *The Doctor* proposes that surgeons should learn compassion by becoming patients in the hospital for a period of time. Playing the patient’s role would sensitize them to what patients go through and make them more compassionate. This may show the trainee the importance of compassion but it would not necessarily introduce them to the kinds of things that can improve compassion and comfort. This movie also suggests that compassion and competence are antithetical; the main character goes to the less competent but highly compassionate otolaryngological surgeon. But why assume these 2 characteristics are in conflict? Why can’t they coexist?

The human values perspective on surgical care seeks to establish the criteria for defining the qualities of a good surgeon. Part of this definition needs to come from individual surgeons who can establish the criteria for manual and clinical skill. Another part comes from patient feedback as well as members of the surgical team. Seeing this as a problem in learning rather than as innate capacity leads to establishing a curriculum for surgical training and research as well as the priorities of surgical organizations.

**SURGICAL TRAINING AND RESEARCH**

Viewing ethics as a series of problems in human values in surgical care creates an agenda for training and research centered on the patient and the role of the surgeon. The basis for this training and research is rooted in the social sciences and humanities as they are applied to patient care. Quantitative and qualitative social science depends on utilizing patient surveys, interview methodology, setting up prospective and retrospective comparative studies, etc. While the surgical trainee and researcher may not know all the scientific details or actually perform the surveys or interviews, they need to know enough about the methods to critically evaluate them. This is the same as training in basic sciences such as immunology, biochemistry, and physiology that surgical trainees receive to apply these methods to the care of surgical patients.

One of the most important applications for surgical research is the application of social science to outcome measures of surgical care. Based on the value orientation described above, what we need ideally is a scoring system that combines the existing measures of surgical outcome (eg, mortality, wound infection, length of stay) with patient-determined measures (eg, satisfaction, functional outcome, social participation). Such a scoring system could look at both simultaneously as well as separately.

Another set of questions that need empirical research are those that address issues around the organization of surgical care. In the age of hospitalists, intensivists, primary care physicians, and surgical assistants, we need to understand the role of the surgeon in preoperative and postoperative care. Examples of questions include: How important is the operating surgeon in postoperative care? Does it matter to patients that the operating surgeon delegates the bulk of postoperative care to assistants or other physicians? What is the best way to approach prolonged absences? How do we best prepare patients for different levels of involvement of the operating surgeon? What is the role of second opinions? How do surgeons function as members of teams of care? With the growing numbers of primary care physicians it seems likely that they will play an adjunctive role in the care of surgical patients. But how is this best managed from the patient’s perspective?

Another area that is beginning to influence patient-centered health care is the use of the Internet. Surgeons are beginning to use e-mail to communicate with patients. How do we maintain confidentiality? How can it be used in preparing for surgery? In follow-up care? Is this a way to get long-term follow-up for the results of individual surgeons on, for example, cancer recurrence rates, hernia recurrence, results of surgery for esophageal reflux?

Besides a background in social science, surgery would benefit by having surgeons with expertise in management. If the manager-surgeon kept the “ethical” view of patient-centered care for here, this would be the best way to keep surgery in the modern, bureaucratic era of health care focused on patient values. While efficiency is a necessary ingredient of modern health care, the issue is, what are we being efficient about? Caring for a fragile, elderly patient with no social support recovering from colon surgery would have a different standard for efficiency than a healthy, young patient with an attentive spouse. A manager-surgeon would appreciate the difference and set up systems and measures that would distinguish between them.

Counseling is another ingredient needed in modern health care systems, especially as we move into the era of genetic medicine. Performing major surgery for patients with a genetic predisposition or risk is already hap-
pening and will likely become more prevalent in the future. But the decision to have major surgery for genetic risk is clearly a matter of individual choice and one that is based on a new kind of scientific information. While surgeons are not likely to be doing all of the counseling around the need for surgery, they clearly should be involved. How should surgeons be involved? What skills do they need? What other professionals are needed, like genetic counselors, and how do they work together?

A final example for surgical research and education based on human values involves resident and continuing education. Surgery is a branch of medicine, and although it involves a major component of technical skill, surgeons are primarily physicians. They have the same medical education and the same licensure requirements and subscribe to the same basic values as other physicians. Therefore surgeons need cognitive as well as technical skills. Cognitive learning includes knowing how to communicate, setting up a management strategy for dealing with complex surgical problems, and appreciating the wide differences in patients as they face major surgical decisions. One way to enhance cognitive learning in human values is to combine the biotechnical and the human issues in case-based learning. A recent example was the case of a 51-year-old architect who developed toxic shock syndrome after a breast biopsy. The discussion included complex wound management, the immunology of toxic shock, and the family conferences about withdrawing the life-supporting ventilator based on the very poor prognosis as well as the fact that all of the patient’s fingers became necrotic during the prolonged period of shock. The data set ranged from wound debridement to substituted judgment and quality of life.

Thus, considering human values as a core ingredient in “ethical” surgical care leads to encouraging surgeons to become more involved in the social sciences and management skills as they apply to surgical care. Trainees would be encouraged to get advanced training in these areas just as traditionally surgeons have been trained in basic science and applied it to the care of surgical patients.

**Surgical Organizations**

Surgical organizations need to expand support for the acquisition of knowledge and skill in the psychosocial aspects of surgical care. This means that meetings, journals, and surgical associations need to foster scholarship and research in the human values aspect of surgical care just as they do on the biotechnical. This is already happening with the annual meeting of the American College of Surgeons hosting several sessions focusing on ethical and psychosocial issues.

Defining the knowledge and skill basis for surgical care will also happen by surgical organizations making some of the human skills part of certification. Testing skills in responding to angry patients, how to deliver bad news, and what to do upon finding a different and more serious problem than expected—all of these circumstances benefit from experience but they also may be dealt with more effectively if the surgeon is prepared, and responds in a proactive rather than just reactive manner.

As surgical organizations incorporate more of the human values perspective they will need to deliberate more about the distribution of surgeons and surgical resources and how they can interact effectively with other national and international agencies. Surgeons have individually always served in underserved areas and countries, but how can surgical organizations promote these efforts more systematically? What about exchange training programs for both American and foreign surgeons?

Political arguments regarding the economic value of surgical care can be more effectively buttressed by an organization that takes human values questions seriously on the front line. The value of surgical judgment, the value of surgical training, and the value of surgical research are all more powerful when the surgical leaders take these quality issues seriously. Some of the newer areas of medical practice like genetics, clinical trials, cost-effectiveness studies all need to be just as much a part of surgical practice as they are of other medical specialties. Training programs and fellowships need to prepare surgeons for incorporating these fields in their clinical armamentarium.

In conclusion, viewing ethics as incorporating human values in surgical practice leads to more formally including attention to the details of patient care, understanding the role of the surgeon in modern health care, constructing research and training programs that accentuate the social sciences and patient-centered management, and, finally, having surgical organizations set standards and a political agenda that enhances these values more explicitly.

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